



## PA05-2002: FOLLICLE STIMULATING REQUEST

### RI MEDICAL ASSISTANCE PROGRAM PRIOR AUTHORIZATION REQUEST FORM

**NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.**

**FAX OR MAIL TO:**  
**HERITAGE INFORMATION SYSTEMS**  
**ATTN: RI PRIOR AUTHORIZATION UNIT**  
**PO BOX 25719**  
**RICHMOND VA 23286-8212**  
**FAX # 1-800-390-0109**

CLIENT NAME \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: M F (CIRCLE ONE - FSH IS COVERED ONLY FOR MALES)  
MEDICAID ID NUMBER: \_\_\_\_\_  
PRESCRIBER NAME: \_\_\_\_\_ PRESCRIBER DEA #: \_\_\_\_\_  
PRESCRIBER OFFICE ADDRESS: \_\_\_\_\_  
OFFICE PHONE NUMBER ( ) \_\_\_\_\_ - \_\_\_\_\_  
REQUESTER NAME: \_\_\_\_\_ RN /MD /R.Ph / \_\_\_\_\_  
PHONE NUMBER ( ) \_\_\_\_\_ - \_\_\_\_\_ FAX NUMBER ( ) \_\_\_\_\_ - \_\_\_\_\_  
DRUG REQUESTED : \_\_\_\_\_ STRENGTH \_\_\_\_\_ QTY / FILL \_\_\_\_\_  
REQUEST TYPE: (CIRCLE ONE) INITIAL / REAUTHORIZATION START DATE: \_\_\_\_\_  
DURATION OF THERAPY: 1 3 6 9 12 MONTHS (CIRCLE ONE) UNITS / RX \_\_\_\_\_ DOSING FREQUENCY: \_\_\_\_\_

**INDICATE THE RELEVANT DIAGNOSIS WITH  
APPROPRIATE ICD-9 CODE.**

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB  
ADDRESS [www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm](http://www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm)

HYPOGONADISM ICD9 CODE \_\_\_\_\_

### COMMENTS:

**PREScriBER SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

*By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.*

PA # \_\_\_\_\_ APPROVED \_\_\_\_\_  
DENIED \_\_\_\_\_  
PENDING ADDITIONAL INFORMATION \_\_\_\_\_  
DATE /TIME OF RECEIPT \_\_\_\_\_  
DATE/TIME RESPONSE \_\_\_\_\_  
REVIEWER \_\_\_\_\_  
COMMENTS: \_\_\_\_\_

**RI PRIOR AUTHORIZATION CALL CENTER**  
**FAX NUMBER 1-800-390-0109 (AVAILABLE 24 HOURS)**  
**TELEPHONE NUMBER 1-866-420-3874**

**RI PRIOR AUTHORIZATION - CALL CENTER HOURS**  
**MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)**  
**SATURDAYS 9:00 AM – 1:00 PM (EST)**

